ICICI Lombard GENERAL INSURANCE

ICICI Lombard Health Care

ADDITIONAL INFORMATION REQUEST FORM

Date: 06-JUN-23

To,

Query Reply

Iclinix Advanced Eye Care
27/171, Vikram Vihar, Near Moolchand Metro Station,
Lajpat Nagar-4
NEW DELHI,Delhi-110024
Tel: Mob:

Dear Sir/Madam,

Claim of	**SHIVANI JOSHI**
UHID	IL18593926000
Policy Number	4016/111550300/07/000
Policy Name	ICICI BANK LTD
Policy Period	01-JAN-2023 to 31-DEC-2023
Date of Admission	09-JUN-2023
AL Number	110201506001

We refer to the Admission request note dated 06-JUN-23 in respect of above claim. After perusal of the same we request you to provide the following information to enable us to process the cashless request.

Sr No	Reason	Description
1	Pre Auth	1. Please note initial Approval stand hold . Kindly provide duly filled Pre-authorization form for further process of cashless. - ATTACHED

Any Other document:

We request you to submit the above information at the earliest to avail the cashless benefit.
NOTE: Query reply not received in 2 days will result in Rejection of the case.

"For any cashless queries, write on cashlessrequest@icicilombard.com"

ICLINIX - Advanced Eye Care Lajpat Nagar-IV N.D.-24

Associate Vice President - Health Claims
ICICI Lombard General Insurance Company Ltd,

ICICI Lombard
GENERAL INSURANCE

ICICI Lombard Health Care

CASHLESS AUTHORIZATION REQUEST NOTE

Toll Free Number: 1800 2666 • Fax Number: 1800 209 8880 / 040 6698 9160 / 61 • Email us: cashlessrequest@icicilombard.com

TO BE FILLED BY THE INSURED / PATIENT

1) Name of Patient: SHIVANI JOSHI

2) Gender: ☐ Male ☑ Female 3) Age: 26 Years 4) Date of Birth: 06/07/1996 5) Mobile No.: 9045580054

6) Insured Card ID No: IL/859/3926000 7) Email ID: _____

8) Policy No. (Retail/Corporate): _____

9) a) Corporate Policy Name: _____ b) Employee ID: _____

10) Currently do you have any other Mediclaim / Health insurance ☐ Yes ☐ No If Yes, Company Name _____

11) a) Name of the family physician: _____ b) Contact Number: _____

12) ID/Age Proof Attached: ☑ Aadhaar Card ☐ Passport ☐ Driving License ☐ 10 th Class Certificate ☐ Others _____

13) *Aadhaar No. of the Proposer/Employee: _____ 14) *PAN No. of the Proposer/Employee: _____

*Mandatory

TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL

1) a) Name of the treating doctor DR MARUD GOGIA b) Mobile No.: 9913924410

2) a) Name of Hospital: ICUNIX ADVANCED EYE CARE b) Contact No.: 8700159684

c) NT Code: _____ d) Email ID: _____ e) Fax No. _____

3) Nature of Illness / Disease with presenting complaints: BOVINE

4) Relevant clinical findings: B/E REFRECTIVE ERROR

5) a) Past history of present ailment, if any: _____

b) Duration of present ailment: ☐☐ Days c) Date of first consultation: D D M M Y Y Y Y

6) a) Provisional diagnosis: B/E REFRECTIVE ERROR

b) ICD 10 Code: _____

7) Proposed line of treatment: ☐ Medical Management ☑ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non allopathic treatment

8) a) If Investigation & / or Medical management, provide details: _____

b) Route of drug administration: _____

9) a) If Surgical, name of surgery: B/E LASIK SURGERY

b) ICD 10 PCS Code: _____

10) If other treatments provide details: _____

11) In case of accident: a) Is it RTA: Y N b) Date of injury: D D M M Y Y Y Y c) Reported to Police: Y N FIR No. _____

12) a) Injury / Disease caused due to substance abuse / alcohol consumption: Y N b) Test conducted to establish this : Y N, attach report.

13) a) In case of Maternity: ☐ G ☐ P ☐ L ☐ A b) Date of Delivery: D D M M Y Y Y Y

PLEASE READ VERY CAREFULLY • THIS FORM IS TO BE FILLED IN BLOCK LETTERS

Details of the patient admitted

a) Date of admission: 09/06/23 b) Time H H : M M

c) Is this an emergency / planned hospitalization event? ☐ Emergency ☑ Planned

d) Expected no. of days stay in hospital: 01 Days e) Room Type: DAYCARE

f) Per Day Room Rent+Nursing & Service Charges+Patient's Diet:	₹	
g) Expected cost for investigation + diagnostics:	₹	
h) ICU Charges:	₹	
i) OT Charges:	₹	
j) Professional fees Surgeon + Anesthetist Fees + consultation Charge:	₹	
k) Medicines + Consumables + Cost of Implants (if applicable Please specify). Other hospital expenses if any:	₹	
l) All inclusive package charges if any applicable:	₹	
Sum total expected cost of hospitalization:	₹	85000/-

Mandatory: Past History of any chronic illness — **If yes, since (Month/year)**

☐ Diabetes	M M Y Y	NO
☐ Heart Disease	M M Y Y	
☐ Hypertension	M M Y Y	
☐ Hyperlipidemias	M M Y Y	
☐ Osteoarthritis	M M Y Y	
☐ Asthma / COPD / Bronchitis	M M Y Y	
☐ Cancer	M M Y Y	
☐ Alcohol or drug abuse	M M Y Y	
☐ Any HIV or STD / Related ailments	M M Y Y	
☐ Other ailments: _____		

DECLARATION

We confirm having read understood and agreed to the Declarations on the reverse of this form

a) Name of the treating doctor: DR SURNAME GOGIA FIRST NAME MIDDLE NAME

b) Qualification: MBBS MD c) Registration No. with state code: DMC-R04624

Signature of treating doctor

ICUNIX Advanced Eye Care Jaipur Nagar-IV N.D.-24

Hospital Seal (Must include Hospital NT ID)

ICUNIX Advanced Eye Care Jaipur Nagar-IV N.D.-24

Patient / Insured Name & Signature: SHIVANI

(PLEASE COMPLETE DECLARATION ON THE REVERSE SIDE OF THIS FORM)

NOT TO BE FAXED/SCANNED

DECLARATION BY THE PATIENT / REPRESENTATIVE

1. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer/T.P.A after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
2. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
3. All non-medical expenses and expenses not relevant to current hospitalization and the amounts over & above the limit authorized by the Insurer/T.P.A not governed by the terms and conditions of the policy will be paid by me.
4. I hereby declare to abide by the terms and conditions of the policy and if at any time the facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the Insurer / T.P.A
5. I agree and understand that T.P.A is in no way warranting the service of the hospital & that the Insurer / TPA is in no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
6. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
7. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the Insurer / TPA.

a) Patient's / Insured's Name: Shivani Joshi

b) Address: _____

c) Contact Number: 9045580054 d) Patient's / Insured's Signature: Shivani

HOSPITAL DECLARATION

1. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
2. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.
3. All non medical expenses, OR expenses not relevant to hospitalization or illness, OR expenses disallowed in the Authorization Letter of the TPA / Insurance Co, OR arising out of incorrect information in the pre-authorisation form will be collected from the patient.
4. WE AGREE THAT TPA / INSURANCE COMPANY WILL NOT BE LIABLE TO MAKE THE PAYMENT IN THE EVENT OF ANY DISCREPANCY BETWEEN THE FACTS IN THIS FORM AND DISCHARGE SUMMARY or other documents.
5. The patient declaration has been signed by the patient or by his representative in our presence.
6. We agree to provide clarifications for the queries raised regarding this hospitalization and we take the sole responsibility for any delay in offering clarifications.
7. We will abide by the terms and conditions agreed in the MOU.

Hospital Seal

Advanced Eye Care
Lajpat Nagar-IV N.D.-24
CLINIX

Doctor's Signature

Dr. Varun Gogia
MBBS(AIIMS), MD(AIIMS)
Director
DMC Reg:- R04624

DOCUMENTS TO BE PROVIDED BY THE HOSPITAL IN SUPPORT OF THE CLAIM

1. Detailed Discharge Summary and all Bills from the hospital
2. Cash Memos from the Hospitals / Chemists supported by proper prescription.
3. Receipts and Pathological Test Reports from Pathologists, supported by note from the attending Medical Practitioner / Surgeon recommending such pathological Tests.
4. Surgeon's Certificate stating nature of operation performed and Surgeon's Bill and Receipt.
5. Certificates from attending Medical Practitioner / Surgeon that the patient is fully cured.

ICICI Lombard Health Care Card

ICICI Lombard Health Care

Company Name: ICICI BANK LTD

Name: SHIVANI JOSHI

Age: 26

Card No: IL18593926000

Valid from: 01-JAN-2023 **Valid To:** 31-DEC-2023

ICICI Lombard Nibhaye Vaade

Toll Free No.: 1800 2666

- *For services like second opinion, doctor appointment, facilitating hospitalization, post hospitalization care, call our Health Assistance Helpline at 040-66274205 (8 AM to 8 PM Monday to Saturday except public holidays)
- This card is nontransferable and is valid at network hospitals only.
- Use of this card is governed by the policy terms and conditions
- Cashless access to the network provider can only be obtained when accompanied with an authorization letter issued by ICICI Lombard GIC Ltd.
- In case of non photo cards, to prove your identity, please produce this card along with any photo id card issued by Government.
- Valid up to policy expiry date or cancellation date whichever is earlier.

ICICI Lombard Health Care Pays: Hospitalisation bills for admissible claim, subject to prior approval. In case of emergency, approval can be taken within 24 hours of hospitalization.
Insured Pays: All non-medical hospitalization bills and expenses not covered under the policy.
Mailing Address: ICICI Lombard Health Care, ICICI Bank Tower, Plot Number 12, Financial District, Nanakram Guda, Gachibowli, Hyderabad – 500 032.
Registered Address: ICICI Lombard General Insurance Company Limited, ICICI Lombard House, 414, Veer Savarkar Marg, Near Siddhivinayak Temple, Prabhadevi, Mumbai – 400 025

Fax Number: (040) 6698 9160/61
Email: ihealthcare@icicilombard.com
Toll Free Number: 1800 2666
Visit us at: www.icicilombard.com

Insurance is the subject matter of the solicitation. IRDA Reg. No.: 115. CIN: L67200MH2000PLC129408
*The mentioned covers are add-ons by paying additional premium and available only if opted by the policyholders.


आयकर विभाग
INCOME TAX DEPARTMENT
भारत सरकार
GOVT. OF INDIA
स्थायी लेखा संख्या कार्ड
Permanent Account Number Card
BJWPJ6653G
नाम / Name
JOSHI
पिता का नाम / Father's Name
DUTT JOSHI
हस्ताक्षर / Signature

भारत सरकार

Government of India

शिवानी जोशी

Shivani Joshi

जन्म तिथि / DOB: 06/07/1996

महिला / Female

7319 3640 0549

मेरा आधार, मेरी पहचान

आधार

भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

पता: D/O पुरषोतम दत्त जोशी, 106 संजय कलोनी, मोहिनी रोड, देहरादून, देहरादून जी.पी0, उत्तराखंड, 248001

Address: D/O Purshottam Dutt Joshi, 106 sanjay colony, mohini road, Dehradun, Dehradun G.p, Uttarakhand, 248001

7319 3640 0549

1947

help@uidai.gov.in

www.uidai.gov.in

Mark of Excellence

E-mail : iclinix@gmail.com

iCLINIX
Advanced Eye Care
"Expert Care by AIIMS Alumni"
Centre for Retina & Lasers

QCI Accredited

Dr. Varun Gogia
MBBS (AIIMS), MD (AIIMS)
Senior Registrar (AIIMS)
Clinical Observer, Cleveland Clinic, USA
Honorary Visiting Consultant : Asan Eye Clinic, Dushanbe, Tajikistan
Senior Consultant Ophthalmology, Fortis C-DOC

Patient ID	16309	**Visit Date/Time**	05/Jun/2023 01:46 PM
Patient Name	Miss. Shivani Joshi	**Age/Sex**	26 Yrs / F
Patient Address	Tower 7 Flat No 202 Gole Avenue 2 Sec 75 Noida	**Contact No.**	9045580054
Category	General	**Old MR No.**	

Present Complaints

Blurring Of Vision.

Vision	Distance Vision		Near Vision	
	Right Eye	Left Eye	Right Eye	Left Eye
With Glass	6/6	6/6	N6	N6
Best Correct	6/6	6/6	N6	N6

Method Name	IOP Time	Right Eye	Left Eye
NCT	12:22	15	16

Adv.Glasses	Right Eye						Left Eye					
	Sph	Cyl	Axis	Prism	V/A	N/V	Sph	Cyl	Axis	Prism	V/A	N/V
Distance	-8.00	-1.25	10		6/6	N6	-8.00	-1.25	180		6/6	N6

Diagnosis Comments/Clinical Impression :

Refractive Error in both eyes

Doctor's Advice :

Plan for LASIK surgery in both eyes

NEXT REVIEW : AS AND WHEN REQUIRED

Dr. Varun Gogia
MBBS(AIIMS), MD(AIIMS)
Director
DMC Reg.:- R04624

Dr.Varun Gogia
MBBS(AIIMS), MD(AIIMS)